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CONFIDENTIAL PHYSICIAN'S REPORT

Driver License Number _____ Date of Birth _____

Name of Patient _____
Last First Middle

1. Nature of condition: _____

2. Will this condition affect the patient's ability to drive a vehicle safely?
☐ Yes ☐ No If Yes, please explain:

2a. Under your current prescribed treatment, can the patient safely operate a motor vehicle?
☐ Yes ☐ No

3. Medications prescribed (please give type and dosage):

4. Will these medications affect the patient's ability to operate a motor vehicle safely?
☐ Yes ☐ No If Yes, please explain:

5. If the nature of the condition indicates loss/lapse of consciousness, seizure activity, fainting or dizzy spells, please **indicate the date of the last occurrence:** _____

6. Please recommend any restrictions you feel are necessary for this patient to drive a vehicle:

7. Please recommend any driving restrictions you feel may be removed from your patient's driver license at this time:

8. Please include any other information you feel is important in evaluating your patient's fitness to drive:

Please complete both sides of this form

PLEASE NOTE: According to Nevada Administrative Code, the Department of Motor Vehicles MUST receive this report within **30** days after the date of the examination.

Date of Examination	Signature of Attending Physician
Physician's Office Phone Number	Please Print Name Of Physician

Office Address of Physician	City	State and Zip

I hereby authorize any physician, surgeon, medical practitioner or other person, and/or any clinic, hospital including the Veteran's Administration or government hospital to release any and all medical information acquired concerning the above specified medical condition or concerning any other medical condition that relates to or affects my ability to operate a motor vehicle safely.

Patient's Signature	Date